5395

Testimony of the
Connecticut Society of Eye Physicians
Connecticut ENT Society
Connecticut Dermatology and Dermatologic Surgery Society
In **Opposition** to
PB 5395 An Act Increasing Penalties for Balance Billing
In the Insurance and Real Estate Committee
February 10, 2009

Good day Senator Crisco, Representative Fontana and other distinguished members of this committee, for the record my name is Dr. Ken Yanagisawa; I am a board certified otolaryngologist practicing in New Haven and Hamden CT. I am here with Kennedy Hudner, our legal counsel, representing over 700 physicians in the ENT, Eye and Dermatology specialties to oppose PB 5395 An Act Increasing Penalties for Balance Billing.

I would like to thank the committee for bringing this issue to public hearing. By doing so it affords us the opportunity to discuss this complicated issue, and share with you our conviction that this bill will jeopardize the rights of patients to choose a physician who does not participate with a Managed care Contract. Furthermore, if this bill is to be voted on by this committee, we would like to suggest the following change that would protect nonparticipating providers.

Line 1. That chapter 735a of the general statutes be amended to require any **participating** health care provider that violates subsection (b) of section 20-7 of the

Non-participating providers are physicians who do not have a contract with a Managed Care Organization (MCO). They are not limited to any terms or conditions of any contract with such companies. Many physicians who are nonparticipating make the decision not to participate in a MCO plan primarily because the MCO offers unacceptable terms or fee schedules for their specialty. Some physicians have a difficult time accepting fees from certain carriers because these reimbursements will not cover the cost of practicing in that area or the benefit plan does not adequately cover the services they provide to their patients.

Patients who want their professional advice must then pay for this particular physician's services out of their own pocket or look for alternative care within their plan's participating provider network.

Participating providers are physicians who have entered into a binding contract with a MCO. These contracts allow for the billing of copayments and deductibles in accordance with the fee schedule that the MCO has on file (a schedule that they continue to hide from public scrutiny) and any non- covered services. These fee schedules are listed numerically by a five digit Current Procedural Terminology(CPT) code. **Participating providers** whose fees exceed the MCO fee schedule are in breach of contract if they balance bill patients for amounts exceeding the fee schedule.

Participating providers at times provide services or sell goods to MCO insured that are not covered under the contract (non-covered services) and are not listed in the fee schedule. For example, it is now common knowledge that cosmetic procedures such as injecting *Restalyne* or *Juvederm* or cosmetic surgery such as eyelid lifts, face lifts, or nose jobs are not covered services under MCO contracts.

Hearing aids are also usually not covered by these MCO contracts or even Medicare, but some plans offer "limited benefits" – which do not come close to covering the cost of the device. If this bill were to pass as written, and physicians did not have the ability to balance bill the patient for these expensive devices, than the consequence will be that no ENT specialist in this state would consider selling hearing aids to patients who have inadequate benefit coverage. Let me give you another problem example with regard to sale of goods. Although cataract surgery is one of the most successful operations in all of medicine, conventional lens implants (IOLs) correct vision at one distance only, and patients with significant astigmatism (unequal corneal curvatures) have to wear glasses to get clear vision at any distance. Premium intraocular lenses are now available that can provide clear vision at distance and near without glasses while other premium lens implants can correct astigmatism.

They are an excellent choice for many patients, but they are not covered by MCO contracts. Some patients are happy to pay a premium fee for these lenses and enjoy an improved quality of life. If this bill were to pass, we would be denying the people of Connecticut the opportunity to control their health care and select the most advanced lenses, and the most appropriate choice for them. The state should not be forcing patients to accept a less expensive option - one the patient did not choose.

PB 5395 does not distinguish between participating and non participating physicians and will ultimately lead to no bargaining power for physicians with MCOs, who offer unreasonable rates, and less access to higher quality medical products, because physicians will simply not sell products that run the risk of financial loss to those patients that have limited benefit plans and will be prevented from balance billing for these products. It will certainly limit anyone from choosing a more sophisticated hearing aid or a better cataract implant. Non-participating providers who extend themselves by filing insurance forms on behalf of their patient would be unduly punished. As a consequence, some patients will seek specialty care out of state. This will also further insure the continued dwindling number of doctors in Connecticut, as recruiting new doctors with new skills becomes ever more difficult. With the number of citizens over 65 expected to double by 2020, we can ill afford to discourage doctors from practicing in Connecticut.

This issue also addresses the need to publish publically the list of CPT codes and services covered under MCO contracts, and a need to formulate a schedule for usual and customary fees for non-participating physicians, who are skeptical about how carriers calculate "usual and customary" fee schedules- especially now that the Ingenix scandal was reported on and is now being investigated by the Attorney General in N.Y and in CT.

In closing, we urge you to oppose PB5395 An Act Requiring Penalties for Balance Billing and consider a study on this important issue, which would protect non-participating physicians, clarify the right of a patient to pay out of pocket for premium devices, allow the physician to provide those devices without fear of penalty, and formulate a reasonable and customary fee schedule for non participating physicians.

Thank you for your consideration of these important issues.

courant.com/business/hc-unitedhealth0114.artjan14,0,4001378.story

Courant.com

OUT-OF-NETWORK HEALTH CARE

Health Care Reimbursement Settlement May Save Consumer Millions

By DIANE LEVICK

January 14, 2009

Consumers nationwide are expected to save millions of dollars on medical care under an industry-changing settlement announced Tuesday aimed at forcing insurers to pay fairer reimbursement to doctors and hospitals outside their networks.

UnitedHealth Group agreed to the $50 million settlement with New York Attorney General Andrew M. Cuomo, but it will also affect members of Aetna, CIGNA, WellPoint and many other health insurers.

The agreement stems from New York's previously announced investigation into a payment system that officials said was rigged to underpay providers of care and maximize insurers' profits.

The system applies to health plans that let members get out-of-network care by paying more of the cost than if they stayed inside a network. More than 100 million Americans have such insurance.

Ingenix, a unit of UnitedHealth that has about 400 employees in Rocky Hill, operates the databases many insurers use to determine what the "reasonable and customary" charge should be for each service in each area. Insurers feed care providers' billing data to Ingenix.

But what insurers decide is reasonable and customary is often less than what out-of-network doctors charge. So once insurers pay their share, patients end up footing an even larger portion of the bills than expected — sometimes suffering severe hardship.

Under the settlement, UnitedHealth will pay $50 million to a nonprofit organization, not yet named, to establish a new independent database that will replace the ones at issue. The nonprofit — possibly a university — will create a website where consumers for the first time would be able to find out in advance how much may be reimbursed for common out-of-network services in their area.

"For the past 10 years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated and manipulated by the health insurance industry," Cuomo said. The agreement, he added, "will keep hundreds of millions of dollars in the pockets of over 100 million Americans."

The agreement does not provide restitution for consumers, and New York is waiting to see what ongoing private lawsuits recover from insurers.

Connecticut Attorney General Richard Blumenthal said his investigation of UnitedHealth and other insurers is continuing, and "we're very focused on possible restitution." The New York settlement is "a very good first step that addresses a portion of the problem," he said.

UnitedHealth general counsel Mitchell Zamoff said at a press conference Tuesday, "We regret conflicts of interest were inherent in these Ingenix database products" and believe the nonprofit will strengthen public confidence in insurers' use of data.

Aetna and CIGNA were among the insurers Cuomo subpoenaed, and he said they are continuing to cooperate with his office. CIGNA noted that out-of-network services represent less than 10 percent of the claims it pays and said the rates it pays providers help the company and its customers manage costs and "reduce upward pressure on member premium rates."

Aetna said the settlement makes sense, and said: "We welcome the attorney general's emphasis on transparency."